

Facility Name & ID Number Heritage Health-Mt Zion

0048074 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	73	Skilled (SNF)	73	26,645	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,645	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,448	5,982	3,093	24,523	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,448	5,982	3,093	24,523	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.04%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started July 2007

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided 3,093

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

Heritage Health-Mt Zion

0048074

Report Period Beginning:

01/01/14

Ending:

12/31/14

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	195,185	15,059		210,244		210,244	3,779	214,023		1
2	Food Purchase		199,707		199,707		199,707	45	199,752		2
3	Housekeeping	66,647	22,001		88,648		88,648		88,648		3
4	Laundry	96,271	8,471		104,742		104,742		104,742		4
5	Heat and Other Utilities			89,151	89,151		89,151	1,031	90,182		5
6	Maintenance	70,592	74,297	43,789	188,678		188,678	12,877	201,555		6
7	Other (specify):*										7
8	TOTAL General Services	428,695	319,535	132,940	881,170		881,170	17,732	898,902		8
	B. Health Care and Programs										
9	Medical Director			22,590	22,590		22,590		22,590		9
10	Nursing and Medical Records	1,356,861	125,495	7,301	1,489,657		1,489,657	219	1,489,876		10
10a	Therapy		363,212	582,210	945,422	(383,651)	561,771		561,771		10a
11	Activities	65,796	913		66,709		66,709		66,709		11
12	Social Services	49,220		6,755	55,975		55,975		55,975		12
13	CNA Training							636	636		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,471,877	489,620	618,856	2,580,353	(383,651)	2,196,702	855	2,197,557		16
	C. General Administration										
17	Administrative	91,114			91,114		91,114		91,114		17
18	Directors Fees										18
19	Professional Services			225,133	225,133		225,133	(208,916)	16,217		19
20	Dues, Fees, Subscriptions & Promotions			76,775	76,775	(39,968)	36,807	(19,778)	17,029		20
21	Clerical & General Office Expenses	128,630	23,274	6,256	158,160		158,160	231,805	389,965		21
22	Employee Benefits & Payroll Taxes			426,975	426,975		426,975	38,153	465,128		22
23	Inservice Training & Education			7,441	7,441		7,441	1,133	8,574		23
24	Travel and Seminar			4,060	4,060		4,060	939	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			42,204	42,204		42,204	8,540	50,744		26
27	Other (specify):*			8,020	8,020		8,020	(8,020)			27
28	TOTAL General Administration	219,744	23,274	796,864	1,039,882	(39,968)	999,914	43,856	1,043,770		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,120,316	832,429	1,548,660	4,501,405	(423,619)	4,077,786	62,443	4,140,229		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							231,161	231,161			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,641	15,641		15,641	73,327	88,968			32
33	Real Estate Taxes							61,882	61,882			33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(323,735)	4,765			34
35	Rent-Equipment & Vehicles			5,417	5,417		5,417	6,029	11,446			35
36	Other (specify):*											36
37	TOTAL Ownership			349,558	349,558		349,558	48,664	398,222			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					383,651	383,651	(33,459)	350,192			39
40	Barber and Beauty Shops			18,761	18,761		18,761		18,761			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					39,968	39,968		39,968			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			18,761	18,761	423,619	442,380	(33,459)	408,921			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,120,316	832,429	1,916,979	4,869,724		4,869,724	77,648	4,947,372			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heritage Health-Mt Zion

0048074

Report Period Beginning: 01/01/14

Ending: 12/31/14

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,805)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,838)			17
18	Fines and Penalties				18
19	Entertainment	(5,067)			19
20	Contributions	(2,020)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,681)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)			24
25	Fund Raising, Advertising and Promotional	(24,052)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (52,463)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	130,111		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 130,111		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 77,648		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Heritage Health-Mt Zion

ID# 0048074

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		(1,838)	20	17
18				18
19			24	19
20		(2,020)	27	20
21				21
22		(4,681)	19	22
23				23
24		(6,000)	27	24
25		(24,052)	20	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(38,591)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health-Mt Zion# 0048074

Report Period Beginning:

01/01/14

Ending:

12/31/14

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,779	0	0	0	0	0	0	0	0	3,779	1
2	Food Purchase	0	0	45	0	0	0	0	0	0	0	0	45	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,031	0	0	0	0	0	0	0	0	1,031	5
6	Maintenance	0	0	12,877	0	0	0	0	0	0	0	0	12,877	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	17,732	0	17,732	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	219	0	0	0	0	0	0	0	0	219	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	636	0	0	0	0	0	0	0	0	636	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	855	0	855	16							
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,681)	(219,445)	15,210	0	0	0	0	0	0	0	0	(208,916)	19
20	Fees, Subscriptions & Promotions	(25,890)	0	6,112	0	0	0	0	0	0	0	0	(19,778)	20
21	Clerical & General Office Expenses	0	0	231,805	0	0	0	0	0	0	0	0	231,805	21
22	Employee Benefits & Payroll Taxes	0	0	38,153	0	0	0	0	0	0	0	0	38,153	22
23	Inservice Training & Education	0	0	1,133	0	0	0	0	0	0	0	0	1,133	23
24	Travel and Seminar	(5,067)	0	6,006	0	0	0	0	0	0	0	0	939	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	8,540	0	0	0	0	0	0	0	0	8,540	26
27	Other (specify):*	(8,020)	0	0	0	0	0	0	0	0	0	0	(8,020)	27
28	TOTAL General Administration	(43,658)	(219,445)	306,959	0	43,856	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(43,658)	(219,445)	325,546	0	62,443	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health-Mt Zion# 0048074

Report Period Beginning:

01/01/14

Ending:

12/31/14

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	216,011	0	15,150	0	0	0	0	0	0	0	231,161	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,805)	82,151	0	(19)	0	0	0	0	0	0	0	73,327	32
33	Real Estate Taxes	0	61,882	0	0	0	0	0	0	0	0	0	61,882	33
34	Rent-Facility & Grounds	0	(328,500)	0	4,765	0	0	0	0	0	0	0	(323,735)	34
35	Rent-Equipment & Vehicles	0	0	0	6,029	0	0	0	0	0	0	0	6,029	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(8,805)	31,544	0	25,925	0	48,664	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(33,459)	0	0	0	0	0	0	0	0	0	(33,459)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	(33,459)	0	0	0	0	0	0	0	0	0	(33,459)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(52,463)	(221,360)	325,546	25,925	0	77,648	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Heritage Enterprises, Inc.</u>	<u>100</u>	<u>Attachment-See Following Page</u>		<u>Heritage Operations Group</u>	<u>Bloomington</u>	<u>Mgmt Svcs</u>
				<u>Green Tree Pharmacy</u>	<u>Minonk</u>	<u>Pharmacy</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$		1
2	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>(33,459)</u>	<u>(33,459)</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>219,445</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(219,445)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>328,500</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(328,500)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>61,882</u>	<u>61,882</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>77,378</u>	<u>77,378</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>216,011</u>	<u>216,011</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>4,773</u>	<u>4,773</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 547,945			\$ 326,585	\$ * (221,360)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.		\$	\$ 3,779	15
16	V	2 Food Purchase					45	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,031	19
20	V	6 Maintenance					12,877	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					219	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					636	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					0	29
30	V	18 Directors Fees					0	30
31	V	19 Professional Services					15,210	31
32	V	20 Fees, Subscription, Promotions					6,112	32
33	V	21 Clerical & General Office Expenses					231,805	33
34	V	22 Employee Benefits & Payroll Taxes					38,153	34
35	V	23 Inservice Training & Education					1,133	35
36	V	24 Travel and Seminar					6,006	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					8,540	38
39	Total		\$			\$	0	\$ * 325,546 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	27 Other	\$	Heritage Enterprises, Inc.		\$	\$	0	15	
16	V	30 Depreciation						15,150	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						(19)	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						4,765	20	
21	V	35 Rent-Equipment & Vehicles						6,029	21	
22	V	36 Other						0	22	
23	V	38 Medically Nec Transportation						0	23	
24	V	39 Ancillary Service Centers						0	24	
25	V	40 Barber and Beauty Shops						0	25	
26	V	41 Coffee and Gift Shops						0	26	
27	V	42 Other						0	27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total		\$			\$	0	\$ *	25,925	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Health-Mt Zion # 0048074 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Heritage Enterprises Inc.	Sole Member		100.00					\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Health-Mt Zion

0048074

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Heritage Operations Group
 Street Address Box 3188
 City / State / Zip Code Bloomington, IL 61701
 Phone Number ()
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,666	25	\$ 134,342	\$ 134,342	75	\$ 3,779	1
2	2	Food Purchase	Beds	2,666	25	1,596	0	75	45	2
3	3	Housekeeping	Beds	2,666	25	0	0	75	0	3
4	4	Laundry	Beds	2,666	25	0	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,666	25	36,640	0	75	1,031	5
6	6	Maintenance	Beds	2,666	25	457,729	82,589	75	12,877	6
7	7	Other	Beds	2,666	25	0	0	75	0	7
8	9	Medical Director	Beds	2,666	25	0	0	75	0	8
9	10	Nursing & Medical Records	Beds	2,666	25	7,786	5,734	75	219	9
10	11	Activities	Beds	2,666	25	0	0	75	0	10
11	12	Social Service	Beds	2,666	25	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,666	25	22,595	21,764	75	636	12
13	14	Program Transportation	Beds	2,666	25	0	0	75	0	13
14	15	Other	Beds	2,666	25	0	0	75	0	14
15	17	Administrative	Beds	2,666	25	0	0	75	0	15
16	18	Directors Fees	Beds	2,666	25	0	0	75	0	16
17	19	Professional Services	Beds	2,666	25	540,681	0	75	15,210	17
18	20	Fees, Subscription, Promotions	Beds	2,666	25	217,245	0	75	6,112	18
19	21	Clerical & General Office Expens	Beds	2,666	25	8,239,911	7,726,747	75	231,805	19
20	22	Employee Benefits & Payroll Tax	Beds	2,666	25	1,356,202	0	75	38,153	20
21	23	Inservice Training & Education	Beds	2,666	25	40,260	0	75	1,133	21
22	24	Travel and Seminar	Beds	2,666	25	213,494	0	75	6,006	22
23	25	Other Admin. Staff Transportatio	Beds	2,666	25	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,666	25	303,574	0	75	8,540	24
25	TOTALS					\$ 11,572,055	\$ 7,971,176		\$ 325,546	25

Facility Name & ID Number Heritage Health-Mt Zion

0048074 Report Period Beginning: 01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization See PG 8
 Street Address _____
 City / State / Zip Code _____
 Phone Number (____) _____
 Fax Number (____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,666	25	\$	75	\$	1
2	30	Depreciation	Beds	2,666	25	538,548	75	15,150	2
3	31	Amortization of Pre-Op & Org	Beds	2,666	25		75		3
4	32	Interest	Beds	2,666	25	(682)	75	(19)	4
5	33	Real Estate Taxes	Beds	2,666	25		75		5
6	34	Rent-Facility & Grounds	Beds	2,666	25	169,393	75	4,765	6
7	35	Rent-Equipment & Vehicles	Beds	2,666	25	214,306	75	6,029	7
8	36	Other	Beds	2,666	25		75		8
9	38	Medically Nec Transportation	Beds	2,666	25		75		9
10	39	Ancillary Service Centers	Beds	2,666	25		75		10
11	40	Barber and Beauty Shops	Beds	2,666	25		75		11
12	41	Coffee and Gift Shops	Beds	2,666	25		75		12
13	42	Other	Beds	2,666	25		75		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 921,565	\$		\$ 25,925	25

Facility Name & ID Number

Heritage Health-Mt Zion

0048074

Report Period Beginning:

01/01/14

Ending:

12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Bank of America		x	Mortgage			\$	\$			\$ 77,378						
2	Bank of America		x	Loan Fee Amortization							4,773						
3																	
4																	
5																	
Working Capital																	
6	Bank of America		x	Working Capital							15,641						
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$ 97,792						
B. Non-Facility Related*																	
10	Interest Income										(8,805)						
11																	
12	Allocated Corporate										(19)						
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ (8,824)						
15	TOTALS (line 9+line14)						\$	\$			\$ 88,968						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health-Mt Zion COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0048074

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>121704210003</u>	_____	\$ <u>61,881.60</u>	\$ <u>61,881.60</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u><u>61,881.60</u></u>	\$ <u><u>61,881.60</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,696 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>50,000</u>	1
2					2
3	TOTALS			\$ <u>50,000</u>	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	73			\$ 1,076,000	\$		\$	\$
5								
6								
7								
8								
Improvement Type**								
9	Environmental Site Study		1998	1,662				
10	Sign		1998	1,860				
11	Air conditioning Unit		1999	5,732				
12	Air Conditioner		1999	750				
13	Professional Fees --Remodeling Project		1999	15,922				
14								
15	Facility Remodel -- Materials		2000	241,637				
16	Professional Fees --Remodeling Project		2000	58,519				
17	Kitchen A/C		2000	990				
18	Fire Alarm		2000	1,997				
19	Door Guard System		2000	3,444				
20								
21	Smoke Detectors		2001	3,775				
22	Water Main Break		2001	3,426				
23	Commercial Disposer		2001	757				
24	Heat Pump		2001	5,158				
25	Carpet Extract		2001	1,206				
26			2001					
27	Facility Remodel -- Contractor		2001	1,397,646				
28	Professional Fees --Remodeling Project		2001	45,077				
29								
30	Facility Remodel -- Contractor		2002	2,762				
31	Fire Dampers		2002	2,766				
32								
33	C/O Allocation				15,150		15,150	
34	Book Depreciation				178,906		178,906	
35								
36								

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health-Mt Zion

0048074

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Asphalt Sealing	2003	\$ 1,447	\$		\$	\$	\$	37
38	Sprinklers	2003	2,680						38
39	Storm Windows	2003	1,173						39
40									40
41	Water Heater	2004	1,114						41
42	Disposal	2004	871						42
43									43
44	A/C Laundry Room	2005	2,968						44
45									45
46	Sidewalk	2006	4,080						46
47	Parking Lot Sealcoat	2006	2,225						47
48	Dishroom rehab	2006	3,631						48
49	Oxygen storage room rehab	2006	3,858						49
50	Fire Alarm	2006	2,249						50
51									51
52									52
53									53
54									54
55	Storage Garage	2007	23,848						55
56	Compressor	2007	4,846						56
57	Water Heater	2007	6,921						57
58									58
59									59
60	Window Replacement	2009	56,034						60
61	HVAC	2009	2,656						61
62	HVAC rooftop	2009	9,250						62
63	Water Heater	2009	7,925						63
64	Parking Lot Sealcoat	2009	31,071						64
65									65
66	Water Heater	2010	16,232						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,056,165	\$ 194,056		\$ 194,056	\$	\$	70

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,056,165	\$ 194,056		\$ 194,056	\$	\$	1
2									2
3	Nurse Call & technology system	2011	184,918						3
4	Carpet	2011	9,016						4
5	Medicare lift	2011	8,334						5
6	Asbestos Abatement	2011	11,601						6
7	Heat Exchange	2011	5,637						7
8	Air Handler Unit	2011	4,714						8
9									9
10	Addison air unit	2012	2,940						10
11	Cast Iron Pipe	2012	3,208						11
12	Generator Control	2012	3,362						12
13	Nurse Call & technology system	2012	3,636						13
14									14
15	Flooring - Room 10	2013	3,173						15
16	Lighting Retrofit	2013	2,887						16
17									17
18	Install Replacement Split System - Laundry Room	2014	9,800						18
19	Schematic Design Fees - Facility Renovation Project	2014	8,428						19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,317,819	\$ 194,056		\$ 194,056	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 688,904	\$ 37,105	\$ 37,105	\$		\$	71
72	Current Year Purchases	54,795						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 743,699	\$ 37,105	\$ 37,105	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,111,518	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 231,161	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 231,161	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heritage Health-Mt Zion

0048074

Report Period Beginning: 01/01/14

Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 5,417 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heritage Health-Mt Zion # 0048074 Report Period Beginning: 01/01/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	226,780	\$		\$	226,780	1
2	Licensed Speech and Language Development Therapist		hrs				69,994				69,994	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs				264,054		943		264,997	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescripts						362,269		362,269	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):						21,382				21,382	13
14	TOTAL			\$		\$	582,210	\$	363,212	\$	945,422	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Health-Mt Zion # 0048074 Report Period Beginning: 01/01/14 Ending: 12/31/14
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 562	\$	1
2	Cash-Patient Deposits	7,987		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	850,915		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,584		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(170,441)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 696,607	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 696,607	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 225,700	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,987		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,383		30
31	Accrued Taxes Payable (excluding real estate taxes)	(20,122)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Assessment Tax</u>	57,993		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 478,941	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 478,941	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 217,666	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 696,607	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 18,248	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 18,248	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	199,418	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 199,418	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 217,666	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 4,448,350	1	
2	Discounts and Allowances for all Levels	(2,015,556)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,432,794	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	1,912,252	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,912,252	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop	721	12	
13	Barber and Beauty Care	18,382	13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	696,188	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services		21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 715,291	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	8,805	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,805	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28			28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,069,142	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	881,170	31	
32	Health Care	2,580,353	32	
33	General Administration	1,039,882	33	
B. Capital Expense				
34	Ownership	349,558	34	
C. Ancillary Expense				
35	Special Cost Centers	18,761	35	
36	Provider Participation Fee		36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,869,724	40	
41	Income before Income Taxes (line 30 minus line 40)**	199,418	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 199,418	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Health-Mt Zion

0048074

Report Period Beginning:

01/01/14

Ending:

12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,800	2,000	\$ 62,026	\$ 31.01	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	9,694	10,424	269,125	25.82	3
4	Licensed Practical Nurses	14,713	15,820	353,801	22.36	4
5	CNAs & Orderlies	50,130	53,903	622,050	11.54	5
6	CNA Trainees		0			6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,559	1,676	49,859	29.75	8
9	Activity Director					9
10	Activity Assistants	4,573	4,917	65,796	13.38	10
11	Social Service Workers	1,840	1,978	49,220	24.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,361	18,668	195,185	10.46	15
16	Dishwashers					16
17	Maintenance Workers	4,013	4,315	70,592	16.36	17
18	Housekeepers	6,159	6,623	66,647	10.06	18
19	Laundry	6,970	7,495	96,271	12.84	19
20	Administrator	1,900	2,080	91,114	43.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,594	6,015	128,630	21.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,306	135,914	\$ 2,120,316 *	\$ 15.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	22,590		36
37	Medical Records Consultant	1,320		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,500		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	6,755		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 35,165		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heritage Health-Mt Zion

0048074

Report Period Beginning:

01/01/14

Ending:

12/31/14

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 39,968
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 270
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Sulaski & Webb
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg Line #	Sch 5 pg Col #	Sch 6 pg Line #	Adjustment Amount			
1009	PETTY CASH	562						1,009	1,009	PETTY CASH 562
1010	CASH IN BANK							1,100	1,100	ACCTS R 850,915
1040	CASH IN BANK-PAYROLL							1,101	1,101	ALLOW. FOR UNCOLLECTIBLE
1100	ACCOUNTS RECEIVABLE	850,915						1,110	1,110	ACCTS RECEIV-M/C
1110	MEDICARE RECEIVABLES							1,125	1,125	ACCTS RECEIV-IPA
1125	IPA INCOME RECEIVABLE							1,135	1,135	ACCTS RECEIV-IC
1130	MEDICARE COST REPORT							1,140	1,140	UNAPPLIED CASH RECEIPTS
1135	ACCOUNTS RECEIVABLE-IC							1,145	1,145	A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS							1,200	1,200	PREPAID 7,584
1145	A/R SUSPENSE-REFUNDS							1,220	1,220	OTHER PREPAID EXPENSES
1190	ACCRUED INTEREST REC							1,300	1,300	DIETARY INVENTORY
1200	PREPAID INSURANCE	7,584						1,310	1,310	SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES							1,320	1,320	LINEN INVENTORY
1300	FOOD INVENTORY							1,409	1,409	LAND 0
1310	SUPPLIES INVENTORY							1,450	1,450	FURNITU 0
1409	LAND	0						1,460		0
1450	FURNITURE & EQUIPMENT	0						1,475	1,475	CODE AL 0
1460	ACCUM DEPR-FURN & EQUIP	0						1,490	1,490	ACCUM I 0
1475	BUILDING & IMPROVEMENTS	0						1,530	1,530	RESIDEN 7,987
1490	ACCUM DEPR-BUILDING	0						1,550	1,550	LOAN FE 0
1530	RESIDENT FUNDS	7,987						1,551	1,551	LOAN FEES ADDED
1550	LOAN FEES	0						1,850	1,850	INTERCO (170,441)
1560	REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUN (225,700)
1575	REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE
1850	INTRACOMPANY	-170,441						2,100	2,100	ACCRUEI (110,482)
2010	ACCOUNTS PAYABLE	-225,700						2,100	2,100	PR CLEARING-BENEFITS
2095	BONUSES PAYABLE							2,100	2,100	PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-110,482						2,110	2,110	ACCRUEI (96,901)
2110	ACCRUED VACATION PAY	-96,901						2,120	2,120	U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	20,122
2125	FICA TAX PAYABLE	20,122	20,122	2,130	2,130 FEDERAL W/H TAX PAYABLE	
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE	
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL	
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE REFU	
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS	
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND	
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETER	
2240	UNITED WAY			2,246	2,250 401K W/H	
2245	GROUP INSURANCE PAYABLE			2,250		
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GA	
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUEI	0
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYM	(57,993)
2300	ACCRUED INTEREST PAYABLE	0		2,350	2,350 REAL EST	0
2310	SALES TAX PAYABLE			2,385		0
2320	IPA PAYMENTS PAYABLE	-57,993		2,400	2,400 CURRENT PORTION OF LT DEB	
2350	REAL ESTATE TAX PAYABLE	0		2,512	2,512 DUE TO F	(7,987)
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE	0
2390	SECURITY DEPOSITS	0		2,600		
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2	
2393	HEART FUND/BAZAAR			2,625		
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DEB	
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINE	(18,248)
2460	INCOME TAXES PAYABLE				net income	(199,418)
2512	DUE TO RESIDENTS	-7,987				
2600	MORTGAGE PAYABLE	0			balance	<u>0</u>
2650	EQUIPMENT LOAN PAYABLE					
2695	CURRENT PORTION LT DEBT					
2696	DEFERRED INCOME TAXES					
2710	COMMON STOCK					
2720	RETAINED EARNINGS	-18,248				
2970	PROFIT/LOSS FOR PERIOD	-199,418				
3007.1	PATIENT DAYS-PRIVATE	5,982				3,007

3007.2	PATIENT DAYS-IPA	15,448						3,007
3007.3	PATIENT DAYS-MEDICARE	3,093						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE & VA	-4,412,005	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARE	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVATE	-34,244	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-696,188	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-1,912,252	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	2,015,556	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0		3,520
3520	16 RENT INCOME	0		6	0	6	0		3,530
3530	13 BEAUTY SHOP	-18,382		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	-721		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	0		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-2,101		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0		4,110
3600	21 MISC INCOME	0		0	0	0	0		4,111
4110	GENERAL & ADMINIST WAGES	119,793	128,630	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	91,114	91,114	17	1	0	0		4,120
4115	VACATION & SICK - G&A	8,837		21	1	0	0		4,121
4120	4475 EMPLOYEE BENEFITS	13,341	426,975	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLORSHIP WAGE	3,749		21	1	0	0		4,250
4135	EMPLOYEE SCHOLORSHIP COST	1,961		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250	4255 OFFICE SUPPLIES	23,274	23,274	21	2	0	0		4,275
4260	TELEPHONE	6,256	6,256	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVL	7,441	7,441	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	3,614	4,060	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	23		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	423		24	3	19	-5,067 ***		4,289
4290	HELP WANTED ADVERTISING	5,335	76,775	20	3	0	0 -39,968		4,290
4291	PROMOTIONAL ADVERTISING	9,661		20	3	25	-9,661		4,291
4292	PUBLIC RELATIONS	14,391		20	3	25	-14,391		4,292
4300	LICENSES & FEES	41,774		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	4,120		20	3	17	-1,838		4,310
4320	CONTRIBUTIONS	2,020		27	3	20	-2,020		4,320
4350	PROFESSIONAL FEES	5,688	225,133	19	3	22	-4,681		4,350
4355	MEDICAL DIRECTOR	22,590	22,590	9	3	0	0		4,355
4360	UTILIZATION REVIEW	0		10	3	0	0		4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0		4,363

4362	MEDICAL RECORDS CONSULT	1,320		10	3	0	0	4,364
4363	PHARMACIST FEES	4,500		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	6,755	6,755	12	3	0	0	4,383
4370	TV RENTAL	4,186		35	3	5	0	4,390
4380	INCOME TAXES		8,020	27	3	26	0	4,400
4383	BACKGROUND CHECKS	1,494		20	3	26	0	4,401
4400	PAYROLL TAXES	186,957		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIST	9,458		22	3	0	0	4,420
4410	GROUP INSURANCE	174,733		22	3	0	0	4,430
4420	LIABILITY INSURANCE	42,204	42,204	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURANCE	36,776		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	219,445		19	3	34	0 **	4,460
4460	BAD DEBTS	6,000		27	3	24	-6,000	4,461
4470	LOST ITEMS-RESIDENTS	0		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	1,231	5,417	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	67,269	70,592	6	1	0	0	4,496
5120	MAINTENANCE SICK & VAC	3,323		6	1	0	0	4,510
5130	ELECTRIC	61,013	89,151	5	3	0	0	4,600
5131	NATURAL GAS	5,874		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	22,264		5	3	0	0	5,130
5134	TRASH COLLECTION	4,905	43,789	6	3	0	0	5,131
5140	PROPERTY PLANT REPLACEMNT	27,556	74,297	6	2	0	0	5,133
5160	GENERAL REPAIR & MAINT	46,741		6	2	0	0	5,134
5165	MAINTENANCE CONTRACTS	38,884		6	3	0	0	5,140
5210	DIETARY WAGES	185,285	195,185	1	1	0	0	5,160
5220	DIETARY SICK & VAC	9,900		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	199,977	199,707	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	3,483	15,059	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	2,423		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	9,153		1	2	0	0	5,260
5295	MEAL CREDIT	-270		2	2	0	0	5,270
5310	LAUNDRY WAGES	87,274	96,271	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	8,997		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	3,999	8,471	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	4,472		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	62,492	66,647	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	4,155		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	18,774	22,001	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-PPR	3,227		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,356,861	10	1	0	0	5,490
6020	RN WAGES-NON MEDICARE	250,396		10	1	0	0	6,020
6030	DON WAGES	62,026		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	18,729		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	329,765		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICARE	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	24,036		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICARE	583,291		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	38,759		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING WAGES	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING REIMB	0		0	0	0	0	6,295
6270	REHAB WAGES	44,281		10	1	0	0	6,390
6275	REHAB SICK & VAC	5,578		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	84,876	125,495	10	2	0	0	7,281
6295	NURSING SUPPLIES	22,201		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	18,418		10	2	0	0	7,391
6490	NURSING OTHER	1,481	7,301	10	3	0	0	7,393
7280	DRUG PURCHASES	154,540	363,212	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	207,729		39	2			7,540
7380	LABORATORY SERVICES	21,382	582,210	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	59,997	65,796	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	5,799		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	913	913	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	264,054		39	3	0	0 ***	7,890
7660	PT SUPPLIES	943		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	44,670	49,220	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & VAC	4,550		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	8,130
7740	OT FEE	226,780		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	69,994		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	18,761	18,761	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	328,500	328,500	34	3	0	0	

8120	INTEREST EXPENSE	15,641	15,641	32	3	14	-8,805	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-8,805		32	0	10	0	
9520	MISC NON-OPERATING INCOME	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	

4,860,919 4,869,724
8,805

GRAND TOTALS

-199,418 -52,463
(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	5,982	5,982
IPA	15,448	15,448
medic	3,093	3,093
		24,523

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3,007 PATIENT

5,982

HFS 3745 (N-4-99)

IL478-2471

3,007 PATIENT	15,448
3,007 PATIENT	3,093
	0
3,010 BASIC CI	(4,412,005)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0
3,080 NURSING	(34,244)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(696,188)
	0
3,110 PHYSICIAN	(1,912,252)
	0
3,112 PHYSICIAN	0
3,113 PHYSICIAN	0
3,140 LABORATORY INCOME	
	0
3,152 ST/OT TR	0
3,153 ST/OT TR	0
3,185 REHABILITATION/ISOLATION/OTHER CHG	
3,410 IPA/OTHER	0
3,411 MEDICAL	0
3,420 MEDICAL	1,912,470

3,520 RENT INC	0
3,530 BEAUTY	(18,382)
	(721)
3,570 VENDING	0
3,590 EQUIPMI	(2,101)
3,595 RESIDEN	0
3,600 MISC INC	0
4,110 G&A WA	119,793
4,111 ADMINIS	91,114
4,115 G&A PTC	8,837
4,120 EMPLOY	9,858
4,130 EMPLOY	3,749
4,135 EMPLOY	1,961
4,250 OFFICE S	9,984
4,255 POSTAGI	2,163
4,260 TELEPHC	6,256
4,275 TRAININ	7,441
	0
4,280 GENERA	3,614
4,281 MEAL EX	23
4,285 EDUCAT	(413)
4,289 MEETING	836
4,290 HELP WA	5,335
4,291 PROMOT	9,661
4,292 PUBLIC I	14,391
4,300 LICENSE	41,774
4,310 DUES & :	4,120
4,320 CONTRIB	2,020
4,350 PROFESS	5,688
4,355 MEDICAL	22,590
	1,320
	4,500

4,364 SOCIAL S	6,755
4,370 TV RENT	4,186
4,383 BACKGR	1,494
4,390 OTHER T	0
4,400 PAYROL	186,957
4,401 PAYROL	9,458
4,410 GROUP I	174,733
4,420 LIABILIT	42,204
4,430 WORKM	35,144
4,435 W/C-FIRS	35
4,436 DRUG TE	1,597
4,450 MANAGI	219,445
4,460 BAD DEF	6,000
4,461 BAD DEF	103,086
4,470 LOST ITE	0
4,475 UNIFORM	3,483
4,486 SERVICE	17,053
4,490 MISC EX	(1,322)
4,496 MISC. M.	11,127
4,510 REAL ES	0
4,600 LEASED	1,231
5,110 MAINTEI	67,269
5,120 MAINTEI	3,323
5,130 ELECTRI	61,013
5,131 NATURA	5,874
5,133 WATER &	22,264
5,134 TRASH C	4,905
5,140 PROP/PL	27,556
5,160 GENERA	46,741
5,165 MAINTEI	21,831
5,210 DIETARY	185,285
5,220 DIETARY	9,900
5,248 FOOD PU	201,299

5,250 SUPPLIE	3,483
5,260 REPLACI	2,423
5,270 KITCHEN	9,153
5,295 MEAL IN	(270)
5,310 LAUNDR	87,274
5,340 LAUNDR	8,997
5,370 REPLACI	3,999
	0
5,390 SUPPLIE	4,472
5,410 HOUSEK	62,492
5,440 HOUSEK	4,155
5,480 SUPPLIE	18,774
5,490 SUPPLIE	3,227
6,020 RN WAG	250,396
6,030 DON WA	62,026
6,035 ADON W	0
6,040 RN PTO &	18,729
6,120 LPN WAG	329,765
6,140 LPN PTO	24,036
6,220 AIDES W	583,291
6,240 AIDES PT	38,759
6,245	0
	0
	0
	0
6,270 REHAB V	44,281
6,275 REHAB F	5,578
6,290 NURSINC	84,876
6,295 NURSINC	22,201
6,390 REPLACI	18,418
6,490 OTHER	1,481

7,280 DRUG PU	154,540
7,281 DRUG PU	207,729
7,380 LABORA	5,862
7,390 X-RAY S	15,520
	0
7,510 ACTIVIT	59,997
7,540 ACTIVIT	5,799
7,590 ACTIVIT	913
7,620 PHYSICA	264,054
7,660 P.T. SUPE	943
7,710 SOCIAL S	44,670
7,720 SOCIAL S	4,550
7,730 SOCIAL S	0
7,740 OCCUPA	226,780
7,770 SPEECH '	69,994
7,820 BEAUTIC	18,761
	0
	0
8,120 INTERES	0
	15,641
8,130 DEPRECI	0
	0
9,510 INTERES	(8,805)
9,520 MISC NO	0
4,220	0
8,100	328,500
9,702	0
5,230	0
	<u>(199,418)</u>

Expenses Fixed Assets

